Catherine Kaplan Ph.D., LLC

Registration Form (rev 1/19)

Date:_________________

Name____
Last First MI

Date of Birth: ______________________ Age: ________ Gender: M F

Street Address: ____

City: ____________________ State: _______ Zip code (+4) ______________

Telephone: Preference order (1-3) Permission to leave a message? (circle one)

_______ Home: ______________________ YES NO

_______ Cell: ______________________ YES NO

_______ Work: ______________________ YES NO

Email Address: ____

Only provide email if you are granting permission to be contacted via email regarding appointments.

If Couples Therapy: Partner's name and phone: ___________________________

Marital Status: Minor Single Married Divorced Widowed Separated

If Client is a Minor, please provide:

PARENT: ______________________________Custodial or Non-custodial (circle one)

Address: ____

Home Phone: ________________ Mobile: ________________ Work: ______________

PARENT: ______________________________Custodial or Non-custodial (circle one)

Address: ____

Non-custodial Parent:

Home Phone: ________________ Mobile: ________________ Work: ______________

Emergency Contact Information: *REQUIRED

Name: ______________________________ Relationship: ____________________

Address: ____

Phone number(s): ____

Employment: Full-time Part-time Unemployed Disability

Employer Name: ____

Employer Address: ____

Student: Full-time Part-time School/College: ____________________ Grade/Year _____

Referred by: (circle one): Psychology Today Doctor Friend Other: ______________________________
If I may send a thank you, please provide: Name: ____
Address: ____Phone: ____________________
Permission to contact: YES NO Signature: ____

Family Doctor: ____ Phone:_____________________
Address: ____

FINANCIAL RESPONSIBILITY:

Name of Financially Responsible Party: ____

DOB ____/_____/_____ Relationship to Client: _________________________________

Address: ____

Phone: ________________________________

Insurance Type(Circle one): PBH or Medicare or Self-Pay Insurance #: _____________________________

I, the undersigned, certify that I (or my dependent) have insurance coverage as specified above. I assign directly to Dr. Kaplan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize Dr. Kaplan to release all information necessary to secure payment of benefits. I will be responsible for all charges and for any missed appointment fees.

Responsible Party Signature: ____________________________________ Date: ____/____/____

THE FOLLOWING MYST BE SIGNED BY ALL CLIENTS, AGE 14 AND OVER. IF CLIENT IS UNDER 14, PARENT MUST SIGN.

For the Client:

My signature below indicates that I have read and understood the office policies of Catherine Kaplan PhD, LLC. I also understand that failure to pay for any services rendered can result in legal action. I give my consent to Catherine Kaplan, PhD, LLC to evaluate and/or treat myself.

Signature: _________________________________ Relationship to client: __________ Date _______

For the Parent/Legal Guardian:

My signature below indicates that I have read and understood the office policies of Catherine Kaplan PhD, LLC. I also understand that failure to pay for any services rendered can result in legal action. I give my consent to Catherine Kaplan, PhD, LLC to evaluate and/or treat my child under the age of 14.

Parent/Guardian Signature: ____________________________ Relationship: _________Date _______